TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Injury 1 Treatment Center

Respondent Name
New Hampshire Insurance Company

MFDR Tracking Number
M4-13-0003

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 4, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The treatment performed was Physical Performance Evaluation not an FCE which is clearly stated on the report and does not require a modifier."

Amount in Dispute: $327.28

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on September 12, 2012. The insurance carrier did not submit a response for consideration in this review. 28 Texas Administrative Code §133.307(d) (1) states in pertinent part, "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." Accordingly, this decision is based on the available information.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 19, 2011	97750	$327.28	$327.28

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 4 – GP required modifier missing or inconsistent w/proced, Service delivered under OP PT care plan

- 193 – Original payment decision maintained
- Note – Per rule 134.204 (g) the documentation for your bill support an FCE-as such, correct modifier is required

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code GP – "required modifier missing or inconsistent w/proce, Service delivered under OP PT care plan." 28 Texas Administrative Code §134.203 (b) states

   For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

   (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

   Review of the submitted information finds:

   a. Service in dispute is 97750 – Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes

   b. The Medicare payment policy is found at www.cms.hhs.gov, Medicare Claims Processing Manual. Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services. Section 10.6 - Functional Reporting, G. Required Reporting of Functional G-codes and Severity Modifiers. "The functional G-codes and severity modifiers listed above are used in the required reporting on therapy claims at certain specified points during therapy episodes of care. Claims containing these functional G-codes must also contain another billable and separately payable (non-bundled) service. Only one functional limitation shall be reported at a given time for each related therapy plan of care (POC). Functional reporting using the G-codes and corresponding severity modifiers is required reporting on specified therapy claims. Specifically, they are required on claims:

      - When an evaluative procedure, including a re-evaluative one, (HCPCS/CPT codes 92521, 92522, 92523, 92524, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 96125, 97001, 97002, 97003, 97004) is furnished and billed;

   The insurance carrier's denial reason is not supported as the disputed service is not included in the above referenced specified therapy claims that require functional reporting modifiers.

   The carrier included a "Note" stating, "Per rule 134.204 (g) the documentation for your bill support an FCE-as such, correct modifier is required." 28 Texas Administrative Code §134.204 (g) states,

   The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC."

   This "note" is not supported as the submitted medical documentation shows "Physical Performance Evaluation" which is also the narrative of the submitted code.

   The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. The services in dispute relates to professional medical services. The applicable rule is 28 Texas Administrative Code 134.203 (c) which states,

To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).

The services in dispute will be calculated as follows;

- Procedure code 97750, service date October 19, 2011. The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.45. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.943 is 0.41492. The malpractice RVU of 0.03 multiplied by the malpractice GPCI of 0.9355 is 0.028065. The sum of 0.892985 is multiplied by the Division conversion factor of $54.54 for a MAR of $48.70. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 20% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $48.70. The PE reduced rate is $44.18 at 7 units is $309.26. The total is $357.96.

3. The total allowable reimbursement for the services in dispute is $357.96. The amount previously paid by the insurance carrier is $0.00. The requestor is seeking additional reimbursement in the amount of $327.28. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $327.28.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $327.28 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

	Peggy Miller	September , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.